

URI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

59-039822

FILED VS DEC 7 1959/39

STATE FILE NUMBER

Registration District No. _____ Primary Registration District No. _____ Registrar's No. 69

ENDED

1. PLACE OF DEATH a. COUNTY <u>HOLT</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MISSOURI</u> b. COUNTY <u>HOLT</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>MOUND CITY</u>		c. CITY OR TOWN <u>MOUND CITY</u>	
Length of stay in 1b <u>8 YEARS</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION		d. STREET ADDRESS (If outside, give location)	
Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>		Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	

3. NAME OF DECEASED (Type or print) First Middle Last <u>JAMES BALLARD RASNIC</u>			4. DATE OF DEATH Month Day Year <u>NOV. 29, 1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>8/18/1873</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ON THE FARM</u>		11. BIRTHPLACE (City and state or country) <u>LEA COUNTY, VA.</u>	
12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>					

13a. FATHER'S NAME <u>WILLIAM RASNIC</u>		13b. MOTHER'S MAIDEN NAME <u>MARTHA LAMBERT</u>		14. NAME OF HUSBAND OR WIFE <u>MINNIE RASNIC</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>		17. INFORMANT <u>MRS. MINNIE RASNIC, MOUND CITY, MO.</u>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) _____ DUE TO (c) _____		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
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19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour _____ a.m. _____ p.m. _____	Month, Day, Year _____		

20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION	COUNTY	STATE
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21. I attended the deceased from July 1, 1959 to NOV 29, 1959 and last saw him alive on NOV 29, 1959
Death occurred at 2 P.M. on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE <u>J. F. Lawrence M.D.</u>	(Degree or title)	22b. ADDRESS <u>Chicago, Mo</u>	22c. DATE SIGNED <u>12-3-59</u>
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23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE <u>12-1-1959</u>	23c. NAME OF CEMETERY OR CREMATORY <u>BENTON CEMETERY</u>	23d. LOCATION (City, town, or county) (State) <u>MOUND CITY MISSOURI</u>
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24. FUNERAL DIRECTOR <u>James H. Crawford, Mound City, Mo.</u>	ADDRESS	25. DATE RECD. BY LOCAL REG. <u>12-3-59</u>	26. REGISTRAR'S SIGNATURE <u>James H. Crawford</u>
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DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.